		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021014

Facility Name: PLEASANT HILL VILLAGE

Address: 1010 WEST NORTH STREET (Number) GIRARD (City) 62640 (Zip Code)

County: MACOUPIN

Telephone Number: (217)627-2181 **Fax #** (217)627-3604

IDPA ID Number: 37-0330985001

Date of Initial License for Current Owners: 3/07/76

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: PAULETTE BUCH-MILLER **Telephone Number:** (217) 627-9502

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/04 to 6/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 10/31/2005 (Date)
(Type or Print Name) PAULETTE BUCH-MILLER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (Date)
(Print Name and Title) SEE ATTACHED COMPILATION REPORT
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,506	14,039		32,545	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,506	14,039		32,545	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.98%

D. How many bed-hold days during this year were paid by the Department?
10 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 3/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/05 Fiscal Year: 6/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,325	11,172	5,248	198,745		198,745		198,745			1
2	Food Purchase		164,190		164,190		164,190	(462)	163,728			2
3	Housekeeping	64,306	7,012		71,318		71,318		71,318			3
4	Laundry	42,602	9,096	1,415	53,113		53,113		53,113			4
5	Heat and Other Utilities			88,431	88,431	(588)	87,843		87,843			5
6	Maintenance	59,458	2,201	9,007	70,666		70,666	(6,898)	63,768			6
7	Other (specify):*											7
8	**TOTAL General Services**	348,691	193,671	104,101	646,463	(588)	645,875	(7,360)	638,515			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,022,925	37,993	275,770	1,336,688		1,336,688		1,336,688			10
10a	Therapy			3,883	3,883		3,883		3,883			10a
11	Activities	59,272	1,618	4,445	65,335		65,335		65,335			11
12	Social Services	25,995	3,054		29,049		29,049		29,049			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* CHAPLAIN	28,077		200	28,277		28,277		28,277			15
16	**TOTAL Health Care and Programs**	1,136,269	42,665	290,298	1,469,232		1,469,232		1,469,232			16
	C. General Administration											
17	Administrative	109,176			109,176		109,176	(12,187)	96,989			17
18	Directors Fees											18
19	Professional Services			40,016	40,016		40,016		40,016			19
20	Dues, Fees, Subscriptions & Promotions			22,767	22,767		22,767	(9,645)	13,122			20
21	Clerical & General Office Expenses	23,808	8,800	11,942	44,550		44,550	(5,110)	39,440			21
22	Employee Benefits & Payroll Taxes			201,588	201,588		201,588		201,588			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,723	3,723		3,723		3,723			24
25	Other Admin. Staff Transportation			833	833		833		833			25
26	Insurance-Prop.Liab.Malpractice			97,450	97,450		97,450		97,450			26
27	Other (specify):* RISK MANAGER	41,814			41,814		41,814		41,814			27
28	**TOTAL General Administration**	174,798	8,800	378,319	561,917		561,917	(26,942)	534,975			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,659,758	245,136	772,718	2,677,612	(588)	2,677,024	(34,302)	2,642,722			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PLEASANT HILL VILLAGE #0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			103,800	103,800		103,800		103,800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,384	32,384		32,384	(7,630)	24,754			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			440	440		440		440			34
35	Rent-Equipment & Vehicles			4,515	4,515		4,515		4,515			35
36	Other (specify):*											36
37	**TOTAL Ownership**			141,139	141,139		141,139	(7,630)	133,509			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					588	588		588			40
41	Coffee and Gift Shops			8,787	8,787		8,787		8,787			41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* **FINES & PENALTIES**			1,755	1,755		1,755	(1,755)				43
44	**TOTAL Special Cost Centers**			64,197	64,197	588	64,785	(1,755)	63,030			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,659,758	245,136	978,054	2,882,948		2,882,948	(43,687)	2,839,261			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(462)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,110)	21		5
6	Rented Facility Space	(2,000)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,630)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,755)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,449)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,196)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,602)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,602)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		(588)	5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ (588)		47

STATE OF ILLINOIS

PLEASANT HILL VILLAGE

ID# 0021014

Report Period Beginning: 7/01/04

Ending: 6/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(462)	0	0	0	0	0	0	0	0	0	0	(462)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(6,898)	0	0	0	0	0	0	0	0	0	(6,898)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(462)	(6,898)	0	0	0	0	0	0	0	0	0	(7,360)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(12,187)	0	0	0	0	0	0	0	0	0	(12,187)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,645)	0	0	0	0	0	0	0	0	0	0	(9,645)	20
21	Clerical & General Office Expenses	(5,110)	0	0	0	0	0	0	0	0	0	0	(5,110)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,755)	(12,187)	0	0	0	0	0	0	0	0	0	(26,942)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,217)	(19,085)	0	0	0	0	0	0	0	0	0	(34,302)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,630)	0	0	0	0	0	0	0	0	0	0	(7,630)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,630)	0	0	0	0	0	0	0	0	0	0	(7,630)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,755)	0	0	0	0	0	0	0	0	0	0	(1,755)	43
44	**TOTAL Special Cost Centers**	(1,755)	0	0	0	0	0	0	0	0	0	0	(1,755)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,602)	(19,085)	0	0	0	0	0	0	0	0	0	(43,687)	45

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		PLEASANT HILL RESIDENCE	GIRARD	INDEPENDENT LIVING CENTER

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	ADMINISTRATIVE WAGES	$ 12,187	PLEASANT HILL RESIDENCE		$	$ (12,187)	1
2	V		6	MAINTENANCE WAGES	6,898	PLEASANT HILL RESIDENCE			(6,898)	2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 19,085			$	$ * (19,085)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HICKORY POINT BANK		X	REFINANCE FACILITY CON	$3,353.00	10/21/03	$ 591,489	$ 555,282	10/15/23	0.0325	$ 18,869	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST NATIONAL BANK		X	OPERATING LINE OF CRED	INTEREST	6/4/04	93,050	270,650	7/31/05	0.0625	12,646	6
7	VARIOUS VENDORS		X	OPERATING SUPPLIES							869	7
8												8
9	TOTAL Facility Related				$3,353.00		$ 684,539	$ 825,932			$ 32,384	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 684,539	$ 825,932			$ 32,384	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		8
	2001		9
	2002		10
	2003		11
	2004		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT HILL VILLAGE COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0021014

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000 B. General Construction Type: Exterior BRICK Frame STEEL & FIRE RESIS Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 29,505
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred: 1973-1976

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	243,065	1905-1975*	$ 28,500	1
2					2
3	TOTALS	243,065		$ 28,500	3

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1976	1976	$ 975,998	$ 24,400	40	$ 24,400	$	$ 715,732	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING, PA SYSTEM PHV SIGN DIRECTORY BOARD			1976	5,916						9
10	DIRECTORY BOARD LETTERS, PATIO CEMENT, LANDSCAPING			1977	1,273						10
11	LANDSCAPING, AIR CONDITIONER, FLAG POLE LIGHT			1978	6,194						11
12	LANDSCAPING, FENCE, CABINETS, INERCOM, & MIKE MIXER			1980	3,688						12
13	REMODELING			1981	485						13
14	ENERGY CONTROL SYSTEM, REMODELING			1982	19,060						14
15	CABINETS			1983	271						15
16	CABINET TOP			1984	408						16
17	GARAGE SHOP, STORAGE BLDG, REMODELING, DRIVEWAY			1985	74,072						17
18	REMODELING			1986	5,469						18
19	BACKFLOW PREVENTOR, WINDOW, & MIXING VALVE			1989	8,180						19
20	FIRE ALARM			1991	1,298						20
21	NEW ROOF, STORM WINDOWS, PAVILION			1992	61,405	37,624		37,624		430,785	21
22	LANDSCAPING			1993	1,240						22
23	LANDSCAPING, ROOF			1994	43,344						23
24	NEW ROOF, REMODELING, AIR CONDITIONERS			1994	32,226						24
25	SECURITY SYSTEM, REMODELING			1994	6,907						25
26	ARCHITECH, REMODELING, A/C, CARPET, FLOOR, PAINT & PAP			1995	40,250						26
27	DRIVEWAY, ARCHITECH, LANDSCAPING, A/C WINDOW TREATN			1995	28,013						27
28	ROOF, WATERLINE, COVEBASE & HAND RAIL			1996	40,657						28
29	LANDSCAPING			1997	915						29
30	ROOF TOP AIR CONDITIONER			1997	6,795						30
31	PAINT & WALL PAPER			1997	24,720						31
32	FLOORING			1997	12,182						32
33	COVEBASE			1997	2,713						33
34	REPLACE CEILING			1997	16,220						34
35	EXHAUST FAN			1997	428						35
36	WATER HYDRANT			1997	527						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING AREA	1998	$ 17,920	$		$	$	$	37
38	LANDSCAPING	1998	715						38
39	ARCHITECH FEES	1998	8,912						39
40	PAINT & WALL PAPER	1998	4,691						40
41	FLOORING	1998	428						41
42	WALL TREATMENTS & PICTURES	1998	442						42
43	WINDOWS	1998	2,123						43
44	OUTDOOR LIGHTING	1998	2,761						44
45	FIRE ALARM SYSTEM	1998	3,218						45
46	HEATING & COOLING SYSTEM	1998	1,824						46
47	LANDSCAPING	1999	1,439						47
48	DEMENTIA WING	1999	287,249						48
49	DEMENTIA WING ELECTRICAL	1999	589						49
50	DEMENTIA WING SURVEY	1999	3,250						50
51	PAINT & WALL PAPER	1999	4,025						51
52	WINDOW TREATMENT	1999	526						52
53	CARPET	1999	2,531						53
54	HEATING & COOLING SYSTEM	1999	4,384						54
55	ROOF TOP AIR CONDITIONER	1999	6,940						55
56	LANDSCAPING	2000	1,600						56
57	DEMENTIA WING	2000	19,566						57
58	SURVEY INDEPENDENT LIVING CENTER	2000	1,875						58
59	SECURITY DOOR ALARM	2000	1,415						59
60	HOT WATER HEATING SYSTEM	2000	26,436						60
61	CARPET	2000	4,462						61
62	VINAL SLIDING DOOR	2000	2,359						62
63	HEATING & COOLING SYSTEM	2000	6,368						63
64	LANDSCAPING	2001	1,600						64
65	ELECTRICAL WORK	2001	850						65
66	MASTER PLAN	2001	10,000						66
67	NEW LAUNDRY ROOM WALL	2001	497						67
68	DUCT WORK	2001	344						68
69	WATER LINE	2001	60,000						69
70	TOTAL (lines 4 thru 69)		$ 1,912,193	$ 62,024		$ 62,024	$	$ 1,146,517	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,912,193	$ 62,024		$ 62,024	$	$ 1,146,517	1
2	SLIDER WINDOWS	2001	2,469						2
3	FLOORING	2001	2,364						3
4	PAINT	2001	475						4
5	FIRE ALARM SYSTEM	2001	3,317						5
6	INTERIOR DECORATING	2001	1,863						6
7	ELECTRIC HEAT UNITS	2001	7,940						7
8	DRIVEWAY	2002	21,209						8
9	SIDEWALK	2002	960						9
10	DOORS	2002	2,515						10
11	AC CONDENCER	2002	1,572						11
12	WINDOWS	2002	266						12
13	EXHAUST FAN	2002	1,802						13
14	COUNTER TOP & WALL REPAIR	2002	604						14
15	ELECTRICAL GROUNDING	2002	2,581						15
16	POLE LIGHT	2002	3,337						16
17	ELECTRIC HEAT	2002	704						17
18	ENTRYWAY CULVERT	2003	2,600						18
19	700' 6" TILE	2003	1,561						19
20	CONCRETE WASHER BASE	2003	750						20
21	PERGOLA	2003	2,800						21
22	MASTER PLAN DEVELOPMENT	2003	892						22
23	HEATER	2003	1,064						23
24	SIGN LIGHTING	2003	2,529						24
25	CARPET	2003	378						25
26	LANDSCAPING	2004	4,748						26
27	ELECTRICAL WORK	2004	1,025						27
28	SECURITY DOOR ALARM	2004	812						28
29	GENERATOR & TRANSFER SWITCH	2004	9,151						29
30	LAUNDRY ROOM A.C.	2004	11,320						30
31	RETAINING WALL GAZEBO AREA	2005	7,254						31
32	ALUMINUM DOORS	2005	2,700						32
33	GAZEBO	2005	7,778						33
34	TOTAL (lines 1 thru 33)		$ 2,023,533	$ 62,024		$ 62,024	$	$ 1,146,517	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,023,533	$ 62,024		$ 62,024	$	$ 1,146,517	1
2	WINDOW TREATMENT	2005	868						2
3	HEAT & COOL SYSTEM	2005	566						3
4	FIRE SAFETY SYSTEM	2005	1,041						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,026,008	$ 62,024		$ 62,024	$	$ 1,146,517	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 281,235	$ 29,438	$ 29,438	$	VARIOUS	$ 172,552	71
72	Current Year Purchases	11,596	420	420		VARIOUS	420	72
73	Fully Depreciated Assets	296,312				VARIOUS	296,312	73
74								74
75	TOTALS	$ 589,143	$ 29,858	$ 29,858	$		$ 469,284	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HOME UPKEEP	PICKUP W/BLADE	2003	$ 2,001	$ 400	$ 400	$	5	$ 933	76
77	RESIDENT OUTINGS	BUS	2003	57,588	11,518	11,518		5	25,915	77
78										78
79										79
80	TOTALS			$ 59,589	$ 11,918	$ 11,918	$		$ 26,848	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,703,240	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,800	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,800	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,642,649	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,515 Description: OFFICE COPIER
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

AIDES WERE ALREADY TRAINED

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 220,214	$	1
2	Cash-Patient Deposits	3,863		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,093)	224,243		3
4	Supply Inventory (priced at COST)	7,391		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,013		6
7	Other Prepaid Expenses	375		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 474,099	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	28,500		13
14	Buildings, at Historical Cost	1,931,895		14
15	Leasehold Improvements, at Historical Cost	94,618		15
16	Equipment, at Historical Cost	648,227		16
17	Accumulated Depreciation (book methods)	(1,642,649)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,505		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,763)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CAPITAL CONTRIB	62,452		22
23	Other(specify): LAND	60,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,198,785	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,672,884	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,380	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,863		28
29	Short-Term Notes Payable	270,650		29
30	Accrued Salaries Payable	55,587		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,743		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,544		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 409,767	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	555,282		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 555,282	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 965,049	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 707,835	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,672,884	$	48

***(See instructions.)**

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 862,610	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 862,610	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(154,775)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (154,775)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 707,835	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,659,075	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,659,075	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	11,184	12
13	Barber and Beauty Care	588	13
14	Non-Patient Meals	462	14
15	Telephone, Television and Radio	3,110	15
16	Rental of Facility Space	2,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,344	23
	D. Non-Operating Revenue		
24	Contributions	12,396	24
25	Interest and Other Investment Income***	7,630	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,026	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	FARM INC 2,343; PHR REIMB 19,085	21,478	28
28a	FUND RAISING 8,427; ENDOWMENT FD 1,823	10,250	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,728	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,728,173	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	646,463	31
32	Health Care	1,469,232	32
33	General Administration	561,917	33
	B. Capital Expense		
34	Ownership	141,139	34
	C. Ancillary Expense		
35	Special Cost Centers	8,787	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37	FINES & PENALTIES	1,755	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,882,948	40
41	**Income before Income Taxes (line 30 minus line 40)****	(154,775)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (154,775)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	1,970	$ 41,649	$ 21.14	1
2	Assistant Director of Nursing	1,818	2,080	41,232	19.82	2
3	Registered Nurses	2,803	2,848	57,244	20.10	3
4	Licensed Practical Nurses	17,658	18,800	291,443	15.50	4
5	CNAs & Orderlies	59,246	62,546	591,357	9.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,138	1,178	10,489	8.90	9
10	Activity Assistants	7,591	7,716	48,783	6.32	10
11	Social Service Workers	2,582	2,830	25,995	9.19	11
12	Dietician					12
13	Food Service Supervisor	2,122	2,226	21,437	9.63	13
14	Head Cook	5,741	5,970	64,589	10.82	14
15	Cook Helpers/Assistants	8,243	8,616	61,324	7.12	15
16	Dishwashers	7,315	7,616	34,975	4.59	16
17	Maintenance Workers	4,396	4,667	59,458	12.74	17
18	Housekeepers	8,322	8,797	64,306	7.31	18
19	Laundry	5,452	5,778	42,602	7.37	19
20	Administrator	4,052	4,076	109,176	26.79	20
21	Assistant Administrator					21
22	Other Administrative	1,992	2,080	41,814	20.10	22
23	Office Manager					23
24	Clerical	1,932	2,190	23,808	10.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CHAPLAIN	1,952	2,080	28,077	13.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,251	154,064	$ 1,659,758 *	$ 10.77	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	164	$ 5,248	L1,C3	35
36	Medical Director	48	6,000	L9,C3	36
37	Medical Records Consultant	45	1,260	L10,C3	37
38	Nurse Consultant	16	800	L10,C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	66	3,300	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	583	L10A,C3	43
44	Activity Consultant	111	4,445	L11,C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	459	$ 21,636		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	34	$ 1,504	L10,C3	50
51	Licensed Practical Nurses	3,623	116,755	L10,C3	51
52	Certified Nurse Assistants/Aides	7,842	150,152	L10,C3	52
53	TOTAL (lines 50 - 52)	11,499	$ 268,411		53

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAULETTE BUCH-MILLER	ADMINISTRATOR	-0-	$ 68,347
MONICA LEDERBRAND	ADMINISTRATOR	-0-	39,303
JULIE ARNETT	ADMINISTRATOR	-0-	1,526
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,176

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CPA FIRM	DATA PROCESSING	$ 30,852
CPA FIRM	AUDIT	3,825
CPA FIRM	COST REPORT	920
DEIHL & NICHELSON LAW OFFI	LEGAL CONSULTATION	190
VINE STREET CLINIC	PROFESSIONAL CONFEREN	1,550
BILL WILSON	COMPUTER CONSULTATIO	1,400
HICKORY POINT BANK	MANAGEMENT FEES	1,279
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,016

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,850
Unemployment Compensation Insurance	462
FICA Taxes	123,737
Employee Health Insurance	9,282
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE X-MAS & INCIDENTAL	9,027
FLEX PLAN ADMINISTRATION	2,230
TOTAL (agree to Schedule V, line 22, col.8)	$ 201,588

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	2,229
Health Care Worker Background Check	1,499
(Indicate # of checks performed 90)	
PUBLIC RELATIONS	3,449
YELLOW PAGE AD	6,196
DUES OTHER	755
DUES ASSOCIATION	7,354
NEWSPAPER & MAGAZINES	535
Less: Public Relations Expense	(3,449)
Non-allowable advertising	( )
Yellow page advertising	(6,196)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,122

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE ATTACHMENT	3,723
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,723

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 7/01/04 Ending: 6/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ASSN BRETHERN CAREGIVERS 3,204; LSN 4,150**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,655**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **GREGORY M. BIERMAN, CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE XI. OWNERSHIP COSTS: PAGE 11

FACILITY GROUNDS CONSIST OF 5.58 ACRES
ORIGINALLY THE LAND WAS SECURED BY DONATION IN 1905 BUT DESIGNATED AS HOME SITE IN 1975
AT WHICH TIME IT WAS APPRAISED AT A VALUATION OF $28,500.

SCHEDULE XI OWNERSHIP COSTS: PAGE 12, 12A, 12B, 12C

IMPORVEMENTS:
SYSTEM DOES NOT DISTINGUISH BY YEAR, ONLY BY ASSET CLASSIFICATION.

Facility Name & ID Number PLEASANT HILL VILLAGE # 21014 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

NAME	DATE	LOCATION	TITLE	SPONSOR	REGISTRATION	MEALS	LODGING	TRAVEL	MILEAGE	
Howard Shockey	9/30/2004	Lake Junaluska	Chaplain	Nat'l Older Adult Ch of Brethern			120	250		
Lenore Holmes	8/24/2004	Chicago	Risk Mgr	LSN	25	30	458	100		
Monica Lederbrand	8/15/2004	Decatur	Administrator	OSHA	35					
Teal Cunningham	########	Breeze	Social Service	OSI					39	
Anne Schmidt	9/15/2004	Decatur	RN	LTC Regional Training	50					
Paulette Miller	9/16/2004	Lincoln	Administrator	Life Service Network	125					
Machelle Martin	9/28/2004	Breeze	Social Service	Social Service Profession	75					
Misty Patrick	10/01/004	Carlinville	Asst Cook	Macoupin Co Public Health De	40					
Shockley, Brandon Stults	10/1/2004	Bloomington	Chaplain, LPN, C N A	Alzheimer's Assn	110					
Martin, Cunningham	10/1/2004	Breese	Social Service	Social Service Prof	225					
Lenore Holmes	10/6/2004	Chicago	Risk Mgr	LSN		35		27		
Fannie Pocklingon	12/1/2004	Peoria	LPN	Life Service Network	95					
Cunningham, Hudgins	########	Springfield	Social Service	Illinois Health Care	190					
Monica Lederbrand	1/1/2005	PHV	Administrator	Life Service Network	115					
Julie Jenkins	1/7/2005	Springfield	Dietary Supervisor	Lincoln Land Comm Coll	252					
Monica Lederbrand	2/1/2005	PHV	Administrator	Life Service Network	115					
Monica Lederbrand	2/25/2005	Decatur	Administrator	Illinois Nursing Home	125					
50% employees	2/25/2005	PHV	VARIOUS	CPR Training	18					
Karen Broaddus	3/31/2005	Springfield	LPN	Outcome Services	360				52	
Julie Jenkins	3/31/2005	Springfield	Dietary Supervisor	Food Show					78	
Monica Lederbrand	5/31/2005	PHV	Administrator	Life Service Network	185	15			81	
Monica Lederbrand	4/1/2005	Springfield	Administrator	Alzheimer's Assn	60					
Susan Akalan	4/20/2005	Springfield	DON	Illinois Health Care	95					
Susan Akalan	5/25/2005	Maryville	DON	Anderson Hospital	45					
Susan Akalan	5/31/2005	Springfield	DON	Life Service Network	99					
					2439	80	578	377	250	3724